STATE OF HAWAII / DEPARTMENT OF HUMAN SERVICES / SOCIAL SERVICES DIVISION

☐ **INITIAL OR** ☐ **RECERTIFICATION** **PROGRAMS: CHECK ONE ONLY:**

(* ITS: Forward original results to CWS FHLU-See page 2, and mail copy to requesting agency)

- ☐ CCFFH/CMA (P)
- ☐ ACCS General (B)
- ☐ ACCS Out-of-State Request (B)
- ☐ Adult Day Care Center (P)
- ☐ Foster Grandparent (B)
- ☐ Senior Companion (B)
- ☐ Respite Companion (B)
- ☐ DOH-ADAD
- ☐ DOH-AMHD
- ☐ DOH-OHCA
- ☐ DOH-DDD
- ☐ DOH-CAMHD (Other Than Ther.Hms/Staff)
- ☐ CWS- Hui Hoomalu & Kokua Ohana Staff (P)*
- ☐ CWS -CCI & CPO Staff & CPO non-therapeutic resources homes (P)*
- ☐ CWS- Catholic Charities HI Hale Malama & HOPE Waiting Keiki Contract Resource Families (B)*
- ☐ CWS Contracts-Other Than Already Noted (eg., CCSS, Ohana Conference, HAP, FSS, VCM, DV, Enhanced Healthy Start Title IV-B 2)
- ☐ DHS-Med-QUEST (Other Than DOH- DDD)
- ☐ DOH-CAMHD- CPO Therapeutic Resource Homes & Staff (P)*
- ☐ DHS-Office of Youth Services (Other Than Safe House Staff)
- ☐ DHS-Office of Youth Services Safe House Staff (P)*
- ☐ CWS Out-of-State Request for CAN Registry
- ☐ CWS General

AUTHORIZATION TO RELEASE INFORMATION FROM THE ADULT/CHILD PROTECTIVE SERVICES CENTRAL REGISTRY

REQUESTING INDIVIDUAL OR AGENCY: (Print or Type all information)

Name: _____ Phone: _____

Address: _____ ATTN: _____

_____ _____

I hereby authorize the Department of Human Services (DHS) or its designee to conduct the following Protective Services Central Registry Check: ☐ **Adult Protective Services (APS)** and/or ☐ **Child Abuse and Neglect (CAN)** on me and to release the information to the requesting individual or agency as indicated above. * Programs with an asterisk-mail copy of results to requesting individual or agency and forward original to CWS FHL Unit noted on the bottom of page 2.

Full name: _____ Date of Birth: _____

Social Security Number: _____ Telephone Number: _____

Any Alias(es)/Former Name, including Maiden Name: _____

_____

Current Address: _____

The information to be released shall be limited to the history of abuse or neglect in which I was identified as a perpetrator and shall include date(s) of CONFIRMED incident(s) only and type of abuse for each incident.

I understand that the information I provide about me shall be used solely for the purpose of conducting the APS and/or CAN Protective Services Central Registry Check. I also understand that the release of this information may be used as part of a background check for employment, volunteer, licensure, or certification purposes which may result in suspension or termination.

This authorization is good until _____/_____/_____ or _____.
Date Event

When no date or event is specified, the authorization shall expire one year from the date the authorization is signed.

Signature: _____ **Date:** _____

Mail or FAX the completed form to: Insights to Success, P. O. Box 1290, Honolulu, Hawaii 96807; or FAX: 532-8331. If you have questions, please call: OAHU: 532-8322 or Neighbor Islands: (877) 532-8322.

**********FOR OFFICIAL USE ONLY**********

Full Name: _____ **Date of Birth:** _____

APS Central Registry Clearance: **The following results are based upon the information provided on Page 1:**

Type(s) of Confirmed Adult Abuse or Neglect:	**Date(s) of Confirmation:**
☐ Caregiver Neglect (Negligent Treatment/Maltreatment)	
☐ Financial Exploitation	
☐ Physical Abuse	
☐ Psychological Abuse	
☐ Self-Neglect (Poor Self-Care)	
☐ Sexual-Abuse	

☐ APS CHECK NOT REQUESTED ☐ NO RECORD OF CONFIRMED ADULT ABUSE ON FILE

CAN Central Registry Clearance: **The following results are based upon the information provided on Page 1:**

Type(s) of Confirmed Child Abuse or Neglect:	**Date(s) of Confirmation:**
☐ Physical Harm/Abuse	
☐ Failure to Thrive	
☐ Threatened Physical Harm/Abuse	
☐ Physical Neglect	
☐ Abandonment	
☐ Lack of Supervision	
☐ Medical Neglect	
☐ Threatened Physical Neglect	
☐ Sex Abuse	
☐ Threatened Sex Abuse	
☐ Psychological Harm	
☐ Abuse	
☐ Neglect	
☐ Threatened Psychological Harm	
☐ Providing a child with dangerous, harmful, or detrimental drugs as defined by Section 712-1240	

☐ CAN CHECK NOT REQUESTED ☐ NO RECORD OF CONFIRMED CAN ON FILE

Clearance Completed by: _____ Date: _____
DHS or Designee Worker's Name Phone Number

DHS-SSD-CWS: *Mail copies of results to requesting agency and forward original results to CWS FHLU.
CWS FHL Unit Address: